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9 **BEFORE THE**  
10 **BOARD OF REGISTERED NURSING**  
11 **DEPARTMENT OF CONSUMER AFFAIRS**  
**STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. 2009-199

13 DIANE STROCK ATKINS

80 Huntington Street, #505

14 Huntington Beach, CA 92648

15 Registered Nurse License No. 542548

16 Respondent.

**ACCUSATION**

17  
18 Complainant alleges:

19 **PARTIES**

20 1. Ruth Ann Terry, M.P.H., R.N. (Complainant) brings this Accusation  
21 solely in her official capacity as the Executive Officer of the Board of Registered Nursing,  
22 Department of Consumer Affairs.

23 2. On or about April 6, 1998, the Board of Registered Nursing issued  
24 Registered Nurse License Number 542548 to Diane Strock Atkins, also known as Diane S.  
25 Russell (Respondent). The Registered Nurse License was in full force and effect at all times  
26 relevant to the charges brought herein and will expire on November 30, 2009, unless renewed.

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1 **JURISDICTION**

2 3. This Accusation is brought before the Board of Registered Nursing  
3 (Board), Department of Consumer Affairs, under the authority of the following laws. All section  
4 references are to the Business and Professions Code unless otherwise indicated.

5 4. Section 2750 of the Business and Professions Code (Code) provides, in  
6 pertinent part, that the Board may discipline any licensee, including a licensee holding a  
7 temporary or an inactive license, for any reason provided in Article 3 (commencing with section  
8 2750) of the Nursing Practice Act.

9 5. Section 2764 of the Code provides, in pertinent part, that the expiration of  
10 a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding  
11 against the licensee or to render a decision imposing discipline on the license. Under section  
12 2811, subdivision (b) of the Code, the Board may renew an expired license at any time within  
13 eight years after the expiration.

14 **STATUTORY PROVISIONS**

15 6. Section 2761 of the Code states:

16 The board may take disciplinary action against a certified or licensed  
17 nurse or deny an application for a certificate or license for any of the following:

18 (a) Unprofessional conduct, which includes, but is not limited to, the  
19 following:

20 (1) Incompetence, or gross negligence in carrying out usual  
21 certified or licensed nursing functions.

22 . . . .

23 (4) Denial of licensure, revocation, suspension, restriction, or any  
24 other disciplinary action against a health care professional license or certificate by  
25 another state or territory of the United States, by any other government agency, or  
26 by another California health care professional licensing board. A certified copy  
27 of the decision or judgment shall be conclusive evidence of that action.

28 . . . .

7. Section 2762 of the Code states:

In addition to other acts constituting unprofessional conduct within the  
meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct  
for a person licensed under this chapter to do any of the following:

1 (a) Obtain or possess in violation of law, or prescribe, or except as  
2 directed by a licensed physician and surgeon, dentist, or podiatrist administer to  
3 himself or herself, or furnish or administer to another, any controlled substance as  
4 defined in Division 10 (commencing with Section 11000) of the Health and  
5 Safety Code or any dangerous drug or dangerous device as defined in Section  
6 4022.

7 (b) Use any controlled substance as defined in Division 10 (commencing  
8 with Section 11000) of the Health and Safety Code, or any dangerous drug or  
9 dangerous device as defined in Section 4022, or alcoholic beverages, to an extent  
10 or in a manner dangerous or injurious to himself or herself, any other person, or  
11 the public or to the extent that such use impairs his or her ability to conduct with  
12 safety to the public the practice authorized by his or her license.

13 . . . .

14 (e) Falsify, or make grossly incorrect, grossly inconsistent, or  
15 unintelligible entries in any hospital, patient, or other record pertaining to the  
16 substances described in subdivision (a) of this section.

17  
18 8. Section 4022 of the Code states:

19 "Dangerous drug" or "dangerous device" means any drug or device  
20 unsafe for self-use in humans or animals, and includes the following:

21 (a) Any drug that bears the legend: "Caution: federal law prohibits  
22 dispensing without prescription," "Rx only," or words of similar import.

23 (b) Any device that bears the statement: "Caution: federal law restricts this  
24 device to sale by or on the order of a \_\_\_\_\_," "Rx only," or words of similar  
25 import, the blank to be filled in with the designation of the practitioner licensed to  
26 use or order use of the device.

27 (c) Any other drug or device that by federal or state law can be lawfully  
28 dispensed only on prescription or furnished pursuant to Section 4006.

9. Section 4060 of the Code states:

No person shall possess any controlled substance, except that furnished to  
a person upon the prescription of a physician, dentist, podiatrist, optometrist,  
veterinarian, or naturopathic doctor pursuant to Section 3640.7, or furnished  
pursuant to a drug order issued by a certified nurse-midwife pursuant to Section  
2746.51, a nurse practitioner pursuant to Section 2836.1, or a physician assistant  
pursuant to Section 3502.1, or naturopathic doctor pursuant to Section 3640.5, or  
a pharmacist pursuant to either subparagraph (D) of paragraph (4) of, or clause  
(iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052.  
This section shall not apply to the possession of any controlled substance by a  
manufacturer, wholesaler, pharmacy, pharmacist, physician, podiatrist, dentist,  
optometrist, veterinarian, naturopathic doctor, certified nurse-midwife, nurse  
practitioner, or physician assistant, when in stock in containers correctly labeled  
with the name and address of the supplier or producer.

Nothing in this section authorizes a certified nurse-midwife, a nurse  
practitioner, a physician assistant, or a naturopathic doctor, to order his or her

1 own stock of dangerous drugs and devices.

2 **COST RECOVERY**

3 10. Section 125.3 of the Code provides, in pertinent part, that the Board may  
4 request the administrative law judge to direct a licensee found to have committed a violation or  
5 violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation  
6 and enforcement of the case.

7 **DRUGS**

8 11. Cocaine is a Schedule II controlled substance as designated by Health and  
9 Safety Code section 11055, subdivision (b)(6), and is a dangerous drug pursuant to Business &  
10 Professions Code section 4022.

11 12. Darvocet N, a brand name for propoxyphene napsylate and  
12 acetaminophen, is a schedule IV controlled substance as designated by Health and Safety Code  
13 section 11057, subdivision (c), and is a dangerous drug pursuant to Business and Professions  
14 Code section 4022.

15 13. Demerol, a brand name for meperidine hydrochloride, is a Schedule II  
16 controlled substance as designated by Health and Safety Code Section 11055, subdivision (b),  
17 and is a dangerous drug pursuant to Business and Professions Code section 4022.

18 14. Percocet, a brand name for acetaminophen and hydrocodone, is Schedule  
19 II controlled substance as designated by Health and Safety Code section 11055, subdivision  
20 (b)(1)(J), and is a dangerous drug pursuant to Business & Professions Code section 4022.

21 15. Versed, a brand name for midazolam HCL, is a Schedule IV controlled  
22 substance as designated by Health and Safety Code section 11507, subdivision (d)(21), and is a  
23 dangerous drug pursuant to Business and Professions Code section 4022.

24  
25 **Division of Investigation Case No. 2007-07-0609**

26 16. Respondent worked as a Registered Nurse at Orange Coast Memorial  
27 Medical Center ("hospital") in Fountain Valley, California, from October 31, 2006 to February  
28 12, 2007, when she was terminated for discrepancies in her narcotics waste practices. The Board

1 received a complaint from the hospital's manager on or about February 14, 2007, regarding  
2 Respondent's termination. The Board referred the matter to the Division of Investigation (DOI)  
3 for an investigation on or about July 19, 2007.

4           17. In a DOI interview on or about September 22, 2008, the hospital's  
5 manager told the investigator that leading up to Respondent's termination, the staff observed  
6 numerous instances of Respondent's improper wasting of controlled substances. The hospital  
7 uses the Pandora Data System ("Pandora"), an automated single-unit dose medication dispensing  
8 system that records information such as patient name, physician orders, the date and time  
9 medication was withdrawn, the name of the licensed individual who withdrew and administered  
10 the medication, the date and time and the witnesses to the wastage of unused or leftover  
11 medications. Shortly after she was hired, on or about November 15, 2006, Respondent  
12 acknowledged receiving nursing orientation training from the hospital which included Sharps  
13 training and pharmaceutical waste review. Respondent was given access to the hospital's  
14 Pandora and regularly withdrew medications for administration to her assigned patients.

15           18. As is the hospital's practice, physicians ordered medications for patients  
16 and the order was logged into Pandora by date, time ordered, drug ordered, and quantity.  
17 Respondent withdrew medications from Pandora and her transactions were recorded in the  
18 system. Medications administered to patients by Respondent were recorded in the patients'  
19 Medication Administration Record (MAR). Respondent entered wastage information into  
20 Pandora. Following an audit of Pandora, it was discovered that there were numerous  
21 discrepancies between the amount of medications removed from Pandora by Respondent, the  
22 amount of medication Respondent charted as administered in the patients' MAR, and the amount  
23 reported wasted. The discrepancies for three patients (A, B, and C) are as follows:

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2 **Patient A**

3 Physician's Order

02/05/07 0920 Meperidine (Demerol) 150 mg/IVP  
02/05/07 0920 Midazolam (Versed) 5 mg/IVP  
02/07/07 0920 Benadryl 50 mg/IVP

5 Medication Administration Record

02/05/07 1035 Administered 25mg/IVP Meperidine (Demerol)  
02/05/07 1035 Administered 1mg/IVP Midazolam (Versed)  
02/05/07 1043 Administered 25mg/IVP Meperidine (Demerol)  
02/05/07 1043 Administered 1mg/IVP Midazolam (Versed)  
02/05/07 1101 Administered 25mg/IVP Meperidine (Demerol)  
02/05/07 1101 Administered 1mg/IVP Midazolam (Versed)  
02/05/07 1107 Administered 25mg/IVP Meperidine (Demerol)  
02/05/07 1107 Administered 1mg/IVP Midazolam (Versed)  
02/05/07 1110 Administered 25mg/IVP Meperidine (Demerol)  
02/05/07 1110 Administered 1mg/IVP Midazolam (Versed)  
02/05/07 1113 Administered 25mg/IVP Benadryl

12 Pandora Data System Transactions

02/05/07 1026 Withdrew 50mg 1 ml/syringe Meperidine (Demerol)  
02/05/07 1026 Withdrew 50mg 1 ml/syringe Meperidine (Demerol)  
02/05/07 1026 Withdrew 50mg 1 ml/syringe Meperidine (Demerol)  
02/05/07 1026 Withdrew 50mg 1 ml/syringe Meperidine (Demerol)  
02/05/07 1027 Withdrew 5mg 5 ml/vial Midazolam (Versed)  
02/05/07 1027 Withdrew 5mg 5 ml/vial Midazolam (Versed)  
02/05/07 1115 Withdrew 50mg 1 ml/syringe Meperidine (Demerol)  
02/05/07 1115 Withdrew 50mg 1 ml/syringe Meperidine (Demerol)  
02/05/07 1115 Withdrew 5mg 5 ml/vial Midazolam (Versed)  
02/05/07 1115 Withdrew 5mg 5 ml/vial Midazolam (Versed)  
02/05/07 1129 Wasted 25mg Meperidine (Demerol)  
02/05/07 1129 Wasted 25mg Meperidine (Demerol)  
02/05/07 1130 Withdrew 50mg Benadryl  
02/05/07 1130 Withdrew 50mg Benadryl

Medications Unaccounted For: 125 mg Meperidine (Demerol)  
15 mg Midazolam (Versed)  
75 mg Benadryl

22 **Patient B**

23 Physician's Order

02/05/07 0701 Meperidine (Demerol) 100 mg/IVP  
02/05/07 0701 Midazolam (Versed) 5 mg/IVP

25 Medication Administration Record

02/05/07 0741 Administered 25mg/IVP Meperidine (Demerol)  
02/05/07 0741 Administered 1mg/IVP Midazolam (Versed)  
02/05/07 0743 Administered 25mg/IVP Meperidine (Demerol)  
02/05/07 0743 Administered 1mg/IVP Midazolam (Versed)  
02/05/07 0751 Administered 25mg/IVP Meperidine (Demerol)  
02/05/07 0751 Administered 1mg/IVP Midazolam (Versed)

02/05/07 0756 Administered 25mg/IVP Meperidine (Demerol)  
02/05/07 0756 Administered 1mg/IVP Midazolam (Versed)

Pandora Data System Transactions

02/05/07 0704 Withdrew 5mg 5 ml/vial Midazolam (Versed)  
02/05/07 0704 Withdrew 5mg 5 ml/vial Midazolam (Versed)  
02/05/07 0704 Withdrew 50mg 1 ml/syringe Meperidine (Demerol)  
02/05/07 0704 Withdrew 50mg 1 ml/syringe Meperidine (Demerol)  
02/05/07 0704 Withdrew 50mg 1 ml/syringe Meperidine (Demerol)  
02/05/07 0704 Withdrew 50mg 1 ml/syringe Meperidine (Demerol)  
02/05/07 0739 Withdrew 5mg 5 ml/vial Midazolam (Versed)  
02/05/07 0739 Withdrew 5mg 5 ml/vial Midazolam (Versed)  
02/05/07 0815 Wasted 1mg Midazolam (Versed)  
02/05/07 0815 Wasted 1mg Midazolam (Versed)

Medications Unaccounted For: 100 mg Meperidine (Demerol)  
14 mg Midazolam (Versed)

Patient C

Physician's Order

02/05/07 0855 Meperidine (Demerol) 100 mg/IVP  
02/05/07 0855 Midazolam (Versed) 5 mg/IVP

Medication Administration Record

02/05/07 0935 Administered 25mg/IVP Meperidine (Demerol)  
02/05/07 0935 Administered 1mg/IVP Midazolam (Versed)  
02/05/07 0940 Administered 25mg/IVP Meperidine (Demerol)  
02/05/07 0940 Administered 1mg/IVP Midazolam (Versed)  
02/05/07 0948 Administered 25mg/IVP Meperidine (Demerol)  
02/05/07 0948 Administered 1mg/IVP Midazolam (Versed)  
02/05/07 0958 Administered 1mg/IVP Midazolam (Versed)

Pandora Data System Transactions

02/05/07 0921 Withdrew 5mg 5 ml/vial Midazolam (Versed)  
02/05/07 0921 Withdrew 5mg 5 ml/vial Midazolam (Versed)  
02/05/07 0921 Withdrew 50mg 1 mg/vial Meperidine (Demerol)  
02/05/07 0921 Withdrew 50mg 1 mg/vial Meperidine (Demerol)  
02/05/07 1019 Wasted 1mg Midazolam (Versed)  
02/05/07 1019 Wasted 1mg Midazolam (Versed)  
02/05/07 1019 Wasted 25mg Meperidine (Demerol)  
02/05/07 1019 Wasted 25mg Meperidine (Demerol)

Medications Unaccounted For: 4 mg Midazolam (Versed)

Respondent documented administering 75mg of Demerol in Patient C's MAR, however, she withdrew 100mg and reported wasting 50 mg.

19. As a result of the discrepancies in the Pandora audit, the hospital conducted an internal investigation. Staff members provided written statements regarding

1 Respondent's suspicious handling of narcotics. Respondent was observed recharting entries in  
2 patients' MARs, carrying a loaded syringe in her pocket, appearing "perkier" after taking breaks,  
3 and being intercepted by another nurse while attempting to take a Sharps container<sup>1/</sup> outside the  
4 hospital. When confronted with the discrepancies, Respondent claimed that she was disposing of  
5 wasted medications into the Sharps containers, but when the containers were opened the  
6 medications were not there. Respondent was asked to submit to a drug screen which came back  
7 positive for cocaine on February 12, 2007. Witnesses stated that Respondent's appearance  
8 became progressively unkempt in the two weeks leading up to her termination.

9           20. On or about November 24, 2008, a DOI Investigator conducted an  
10 interview with Respondent. Respondent stated she was terminated from the hospital due to  
11 improper wasting of drugs. Respondent stated she was drug tested in connection with her  
12 termination but tested negative for the suspected drugs. Respondent claimed the positive test for  
13 cocaine came from diet pills she purchased online from Mexico; she never used cocaine in her  
14 life. In discussing the specifics of the discrepancies of Patients A, B, and C on February 5, 2007,  
15 Respondent stated that she may have used excess medications from one patient on another  
16 patient. She also stated that she may have wasted medications into the Sharp's container.  
17 Respondent stated that she was in denial and would discard medications at the end of the day and  
18 would not waste them properly. Respondent could not account for the missing 225mg of  
19 Demerol and 29mg of Versed.

#### 20                           **FIRST CAUSE FOR DISCIPLINE**

##### 21                   **(Incompetence & Gross Negligence in Carrying Out Nursing Functions)**

22           21. Respondent has subjected her license to disciplinary action under section  
23 2761, subdivision (a)(1) of the Code in that on or about February 5, 2007, Respondent was, and  
24 admitted to being, incompetent and grossly negligent in performing her duties as a registered

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26           1. A Sharps container is filled with used medical needles (and other sharp medical  
27 instruments, such as an IV catheter). They fit into two main types: a single use container which  
28 is disposed of with the waste inside, and a reusable container which is robotically emptied and  
sterilized before being returned for re-use. A Sharps container is never used to hold wasted  
medications.

1 nurse when she failed to properly chart the administration of controlled substances in patients'  
2 MARs, failed to properly dispose of wasted medications, and failed to account for missing  
3 narcotics while employed at Gold Coast Memorial Medical Center as described in paragraphs  
4 18-20, above.

5 **SECOND CAUSE FOR DISCIPLINE**

6 **(Use of a Controlled Substance)**

7 22. Respondent has subjected her license to disciplinary action under section  
8 2762, subdivision (b) of the Code in that on or about February 8, 2007, Respondent submitted to  
9 a drug screen at Gold Coast Memorial Medical Center. On or about February 12, 2007, the drug  
10 screen test results were positive for cocaine, as described in paragraphs 19-20, above. Orange  
11 Coast does not maintain an inventory of cocaine. Respondent's use of cocaine impaired her  
12 ability to safely conduct nursing in that she reported for work with a measurable amount of  
13 cocaine in her system, which means she was working under the influence of cocaine.

14 **THIRD CAUSE FOR DISCIPLINE**

15 **(Falsify or Make Grossly Incorrect Entries**

16 **in a Record Pertaining to Controlled Substances)**

17 23. Respondent has subjected her license to disciplinary action under section  
18 2762, subdivision (e) of the Code in that on or about February 5, 2007, Respondent knowingly  
19 falsified or otherwise made grossly incorrect entries in three patients' MARs when she failed to  
20 properly document controlled substance administration and wastage while employed by Gold  
21 Coast Memorial Medical Center, as described in paragraph 20, above.

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**Division of Investigation Case No. 2007-07-0977**

24. On or about May 7, 2008, the Board received a Consumer Complaint from a physician who treated Respondent on or about March 31, 2008. At that time, the physician gave Respondent a prescription for Darvocet N-100. Respondent claimed to have a headache and specifically asked for Darvocet. The physician noted that Respondent's speech was slurred; Respondent stated that she had slurred speech and headaches due to a neurological problem.

25. On or about March 31, 2008, Respondent went to a Walgreen's drug store in Huntington Beach and presented the prescription to a pharmacy technician at the drop-off window. The pharmacy technician brought the prescription to the pharmacist for verification. The pharmacist noticed that the prescription appeared to be altered; quantities were changed, the writing was traced, as well as other alterations. The pharmacist faxed the prescription to the physician who issued it and was told by the physician that it had been altered.

26. As a result of the complaint, the Board requested that DOI conduct an investigation. On or about November 4, 2008, a DOI investigator interviewed the physician in her Fountain Valley office. The physician provided the investigator with a copy of the forged prescription and highlighted the areas of the prescription that had been altered. Respondent added Percocet to the prescription and changed the quantity of the Darvocet. The physician told the investigator that she would never prescribe Darvocet and Percocet together unless it was for a patient with last stage cancer. The physician also stated that when she spoke to the pharmacist about the forged prescription, Respondent had told the pharmacist that she had been diagnosed with a brain tumor. Respondent e-mailed the physician the following day apologizing for her actions. The physician identified Respondent from a photo line-up.

27. On or about November 5, 2008, the DOI investigator interviewed the Walgreen's pharmacist. The pharmacist stated that after she verified that the prescription had been altered, the pharmacist confronted Respondent and told her the physician may press charges against her. Respondent stated that someone else forged the prescription. The pharmacist told Respondent that it did not matter because Respondent was the person attempting to fill the forged prescription. The pharmacist stated that Respondent did not appear to be under the

1 influence of drugs at the time. The pharmacist identified Respondent from a photo line-up.

2 28. In a telephone interview with the investigator on or about November 12,

3 2008, Respondent stated "I was medicating myself." On or about November 24, 2008, in

4 conjunction with the investigation detailed in paragraphs 16-20, Respondent met with the

5 investigator. Respondent stated that she did not remember anything about the incident because

6 she was in a horrible state of mind and on psychiatric medications that caused memory lapses.

7 Respondent stated that she illegally purchased Paxil online and admitted to self-medicating.

8 Respondent claims she remembered nothing of her visit with the physician, the prescription she

9 received, the alterations, or her attempt to fill the prescription at Walgreens. Respondent agreed

10 the prescription had been altered and acknowledged she sent the e-mail to the physician.

11 Respondent provided the investigator with a copy of an article about nurse burnout and said it fit

12 her description. Respondent stated she was currently under the care of two physicians (doctors

13 "A" and "D") and provided a list of her current medications and a signed release to access her

14 medical records. Respondent admitted that she had called-in a prescription for Vicodin while

15 working as a registered nurse in Georgia. Respondent denied having a substance abuse problem

16 and agreed to provide a urine specimen to the investigator. While she was in the bathroom stall

17 Respondent told that investigator that she would kill herself if she had to go to jail. On or about

18 November 26, 2008, the results of the drug screen tested positive for barbiturates and

19 benzodiazepines.

20 29. On or about December 3, 2008, the DOI investigator conducted a

21 telephone interview with Dr. A. who stated the positive results for benzodiazepines would be

22 consistent with the Alprazolam he prescribed to Respondent, however, he denied prescribing

23 barbiturates. He stated that barbiturates were seldom used for anything, they were hard to get,

24 and it would take some finessing by Respondent to obtain them. The investigator told Dr. A.

25 that Respondent claimed she ordered Paxil online and blamed the Paxil for memory lapses,

26 including the event with the forged prescription. Dr. A. described Respondent's story as "far-

27 fetched."

28 30. On or about December 8, 2008, the DOI investigator conducted a

1 telephone interview with Dr. D. who denied she ever prescribed barbiturates to Respondent. Dr.  
2 D. stated she only saw Respondent three times and that Respondent was also seeing a  
3 rheumatologist in Huntington Beach due to joint aches and pains.

4 31. On or about December 9, 2008, Respondent called the DOI investigator  
5 asking for an update. The investigator asked Respondent why she tested positive for  
6 barbiturates. Respondent stated she was taking Xanax. The investigator told Respondent that  
7 Xanax was not a barbiturate. Respondent then stated that it might be due to the Ambien she was  
8 prescribed by Dr. A, which she was taking along with Celexa and Xanax. (Ambien was not on  
9 the list of medications she previously provided the investigator.) The investigator confirmed  
10 with Dr. A. that it was unlikely that Ambien would cause a positive result for barbiturates.

#### 11 **FOURTH CAUSE FOR DISCIPLINE**

##### 12 **(Illegally Obtaining a Prescription for Controlled Substances)**

13 32. Respondent has subjected her license to disciplinary action under section  
14 2762, subdivision (a) of the Code in that on or about March 31, 2008, Respondent knowingly  
15 altered a physician's prescription by changing the quantity of the prescribed Darvocet, and  
16 adding a prescription for Percocet in violation of section 4060 of the Code, as described in  
17 paragraphs 24-27, above.

#### 18 **FIFTH CAUSE FOR DISCIPLINE**

##### 19 **(Use of a Controlled Substance)**

20 33. Respondent has subjected her license to disciplinary action under section  
21 2762, subdivision (b) of the Code in that on or about November 24, 2008, Respondent submitted  
22 to a drug screen at the DOI's Lakewood Field Office. On or about November 26, 2008, the  
23 results of the drug screen tested positive for barbiturates, a class of drugs not prescribed by  
24 Respondent's medical providers, as described in paragraphs 29-31, above. Respondent further  
25 admitted to illegally purchasing Paxil online without a prescription in violation of section 4060  
26 of the Code, and admitting to self-medicating with illegally procured drugs as set forth in  
27 paragraphs 28-31, above.

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**SIXTH CAUSE FOR DISCIPLINE**

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**(Discipline By Another State)**

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34. Respondent has subjected her license to disciplinary action under section 2761, subdivision (a)(4) of the Code in that Respondent's license to practice registered nursing was suspended by another state. The circumstances are as follows:

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a. Respondent was issued registered nurse license no. RN117516 by the Georgia Board of Nursing on or about July 12, 1994.

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b. As a result of a disciplinary action entitled *In the Matter of: Diane Strock Atkins*, file no. 64EB-CA-1061141, it was alleged Respondent inappropriately medicated patients and diverted narcotics. On or about April 13, 2005, the Georgia Board of Nursing ordered Respondent to undergo a mental and physical examination within fourteen (14) days of receipt of the order, and that the results of said examination were to be received by the board within thirty (30) days of receipt of the order. Respondent received the order on or about April 29, 2005, but failed to comply with the order.

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c. On or about September 8, 2006, Respondent consented to an order suspending her registered nurse license effective September 25, 2006. Respondent was entitled to renew her license during the period of suspension and was advised that failure to do so would result in the revocation of her license.

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d. Respondent's registered nurse license no. RN117516 issued by the Georgia Board of Nursing expired on or about January 31, 2008 and has not been renewed.

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1 PRAYER


2 WHEREFORE, Complainant requests that a hearing be held on the matters herein  
3 alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

4 1. Revoking or suspending Registered Nurse License Number 542548,  
5 issued to Diane Strock Atkins;

6 2. Ordering Diane Strock Atkins to pay the Board of Registered Nursing the  
7 reasonable costs of the investigation and enforcement of this case, pursuant to Business and  
8 Professions Code section 125.3;

9 3. Taking such other and further action as deemed necessary and proper.  
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11 DATED: 3/16/09  
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13   
14 RUTH ANN TERRY, M.P.H., R.N.  
15 Executive Officer  
16 Board of Registered Nursing  
17 Department of Consumer Affairs  
18 State of California  
19 Complainant

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